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86-1.82 Health personnel development and practitioner placement programs.

(a) $4.5 million shall be allocated for rate adjustments to be made available for a health occupation development and workplace programs. Funds shall be allocated based upon budgeted costs of the program which are determined by the Commissioner to be reasonable. Such adjustments shall be made available for the duration of the programs. Eligible costs shall include but not be limited to: start up costs, employee training expenses, staff costs, supplies, equipment and capital costs, and administrative costs.

(1) Hospitals shall be eligible for rate adjustments to develop, implement and evaluate programs and projects to test new technologies, new models of organizing tasks and services and other strategies to improve efficiency and productivity of existing hospital personnel and reduce time that patient staff spend meeting paper work and documentation requirements. The following factors shall be considered in determining rate adjustments:

(i) the potential for replicating the proposed program in other facilities;

(ii) the extent to which organizations seeking approval to operate a program under this section sought the direct participation of health care workers, and any collective bargaining unit which represents such workers, in the development of the proposal;

(iii) the impact the proposed program would have on the recruitment of and retention of health care workers, and the effective utilization of the existing workforce; and

(iv) the extent to which the proposed program would improve the quality of care provided to patients.

(2) The commissioner is authorized to waive, modify or suspend the respective provisions of rules and regulations promulgated pursuant to the Public Health [redacted] the commissioner determined that such waiver, [redacted] for the successful implementation

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of a program and provided that the Commissioner determines that the health, safety, and general welfare of people receiving health care under such program will not be impaired as a result of such waiver, modification or suspension.

(3) Hospitals shall make application to the Department of Health for such rate adjustments. Except for rate year 1991, hospitals shall make application by October 15 of the rate year preceding the rate year of the program.

(b) $500,000 shall be made available for practitioner placement programs to assist general hospitals in the recruitment, placement and training of physicians and other health care practitioners to practice primary health care and/or dentistry in undeserved areas (both rural and urban), to serve the medically needy, and including services with affiliated community based providers. The funds shall be allocated based on the budgeted costs of the programs which are determined by the Commissioner to be reasonable, and shall be made after consideration of but not limited to the potential for implementing the proposed program on a statewide basis. Notwithstanding any inconsistent provision of this subdivision, this clause shall not apply in rate periods commencing on or after January 1, 1994. Loan repayment awards to attract medical students and residents to urban areas shall not exceed $7,500 per student.

(c) $34 million shall be allocated to those general hospitals providing comprehensive health care to the communities they serve. The allocation shall be based on a total number of points received by each general hospital relative to other general hospitals statewide. The factors to be considered in determining which general hospitals are providing comprehensive health care and the manner in which points shall be awarded to the general hospital for these factors shall include but not be limited to.

(1) 1989 clinic and emergency room volume compared to inpatient volume, as measured by specific subfactors as follows:

(i) emergency room volume shall be calculated as a percentage of inpatient discharges for all payors.

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of a program and provided that the commissioner determines that the health, safety and general welfare of people receiving health care under such program will not be impaired as a result of such waiver, modification or suspension.

(3) Hospitals shall make application to the Department of Health for such rate adjustments. Except for rate year 1991, hospitals shall make application by October 15 of the rate year preceding the rate year of the program.

(b) $500,000 shall be made available for practitioner placement programs to assist general hospitals in the recruitment, placement and training of physicians and other health care practitioners to practice primary health care in underserved areas (both rural and urban), to serve the medically needy, and including services with affiliated community based providers. The funds shall be allocated based on the budgeted costs of the programs which are determined by the Commissioner to be reasonable, and shall be made after consideration of but not limited to the potential for implementing the proposed program on a statewide basis. Loan repayment awards to attract medical students and residents to urban areas shall not exceed $7,500 per student.

(c) $34 million shall be allocated to those general hospitals providing comprehensive health care to the communities they serve. The allocation shall be based on a total number of points received by each general hospital relative to other general hospitals statewide. The factors to be considered in determining which general hospitals are providing comprehensive health care and the manner in which points shall be awarded to the general hospital for these factors shall include but not be limited to,

(1) 1989 clinic and emergency room volume compared to inpatient volume, as measured by specific subfactors as follows:

(i) emergency room volume shall be calculated as a percentage of

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(ii) Medicaid and self-pay/no pay emergency room volume shall be calculated as a percentage of total emergency room volume.

(iii) clinic volume for all payors shall be calculated as a percentage of inpatient discharges for all payors.

(iv) Medicaid and self pay/no pay clinic volume shall be calculated as a percentage of total clinic volume.

(2) 1989 inpatient discharges with a secondary diagnosis of drug and/or alcohol abuse as a percent of total inpatient discharges.

(3) The 1989 inpatient Medicaid and self pay/no pay volume as a percent of total inpatient volume.

(4) Points will be awarded for each of the subfactors calculated in subparagraphs (i), (ii), (iii), and (iv) of paragraph (1), and for each of the factors calculated in paragraphs (2) and (3), based on evaluating each general hospital's percentage against other general hospitals in its respective region and against all general hospitals statewide. The regions to be used for such purpose shall be Article 43 insurance plan regions as modified by section 86-1.65 (h) of this Subpart.

(5) An increase in the percentage of medicaid inpatient discharges to total discharges for all payors from 1987 to 1989. Points shall be awarded to each general hospital based on evaluating each general hospital's change compared to all other general hospitals statewide.

(6) The number and types of clinic services offered and the degree of availability of such services. Points shall be awarded to each general hospital based on the number of clinic services available; the accessibility to clinic services during weekend or evening hours; and having available satellite sites.

(7) Each general hospital shall be awarded points according to the number of the following services: AIDS designated center, prenatal home health care program; trauma center; burn center;

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neonatal intensive care services; birthing center back-up; dialysis services; mental health, drug and alcohol programs designated pursuant to section 9.39 of the Mental Hygiene Law; designates 911 receiving hospital; syphillis testing as part of a routine standard of care; and services to correctional patients.

(8) For each general hospital, the sum of points awarded for the factors and subfactors in accordance with paragraphs (1) through (8) of this subdivision shall be determined. Those general hospitals having a minimum number of summed points (20.5), as determined by the commissioner to be the indicia of the most comprehensive level of services provided their communities shall be eligible for the allocation under this subdivision.

(9) For those general hospitals whose summed points meet or exceed the minimum number determined in paragraph (8) of this subdivision, a percentage adjustment shall be made to each eligible general hospital's 1991 non-Medicare reimbursable operating cost base based upon each general hospital's summed points such that: the percentage adjustment shall be proportional to the eligible general hospital's summed points, the percentage adjustment may not result in any less than or any more than specified dollar amounts as determined by the Commissioner, and the sum of all dollar amounts resulting from such percentage adjustments shall total 34 million dollars.

(d) Any portion not allocated in accordance with subdivision (a) through (c) of this section shall be reallocated to further fund the adjustments specified in clauses (c) and (d) of section 86-1.52(a)(1)(iv) and subdivision (c) of this section in the same proportion as their original funding.

86-1.84 Supplementary Low Income Patient Disproportionate Share Adjustment.

(a) The rates of payment for the periods between January 1, 1991 through July 31, 1991 and August 1, 1991 through December 31, [~~1993~~] 1995 for persons eligible for federal financial participation under title XIX of the federal Social Security Act in medical assistance paid by State governmental agencies pursuant to Title 11 of Article 5 of the Social Services Law, shall include for eligible general hospitals a supplementary low income patient disproportionate share adjustment determined pursuant to subdivision (b) of this section.

(b) The supplementary low income patient adjustment shall be determined by multiplying the applicable supplemental percentage coverage of need amount for the hospital as specified in paragraph (2) of this subdivision by the hospital's need as defined in subdivision (b) of section 86-1.65 of this Subpart and calculated using 1989 data for the period January 1, 1991 through December 31, 1993 and calculated using 1991 data for public hospitals, voluntary non-profit or private proprietary general hospitals for the period January 1, 1994 through December 31, 1995. This amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable costs and divided by the service units of those Medicaid patients eligible for Federal financial participation under Title XIX of the federal Social Security Act in medical assistance pursuant to Title 11 of Article 5 of the Social Services Law, to arrive at the supplementary low income patient disproportionate share adjustment per unit of service.

(1) The low income patient percentage shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical

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assistance pursuant to title 11 of article 5 of the Social Services Law, inpatient discharges of self pay patients[1] and inpatient discharges of charity care patients divided by total patient discharges expressed as a percentage. The percentages for the period January 1, 1991 through December 31, 1993 shall be calculated based on base year 1989 data from the statewide planning and research cooperative system (SPARCS), which was received by the department no later than November 1, 1990. The percentages for the period January 1, 1994 through December 31, 1995 shall be calculated based upon 1991 data from the statewide planning and research cooperative systems (SPARCS), which was received by the Department no later than November 1, 1993.

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Supersedes TN 92-46 Effective Date JAN 01 1994

[1] NOTE: Self pay patients represent patients who are uninsured and who are not full pay patients.

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(2)(i) The scale utilized in the development of a hospital's supplementary low income patient disproportionate share adjustment for the period January 1, 1991 through June 30, 1991 shall be as follows:

Low income patient percentages	Supplemental percentage coverage of need
50+ to 55%	5.0%
55+ to 60%	10.0%
60+ to 65%	15.0%
65+ to 70%	22.5%
70+ to 75%	30.0%
75+ to 80%	37.5%
80+	45.0%

(ii) The scale utilized for development of a hospital's supplementary low income patient adjustment for the period August 1, 1991 through December 31, [~~1993~~] 1995 for a public hospital and August 1, 1991 through September 30, 1992 for a voluntary non-profit or a private proprietary general hospital shall be as follows:

Low Income Patient Percentages	Supplemental Percentage coverage of Need
35+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+%	45%

(iii) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment for the period October 1, 1992 through March 31, 1993 and for the period January 1, 1994 through December 31, 1995 shall be as follows:

Low Income Patient Percentage	Supplemental Percentage coverage of Need
35+ to 50%	10%
50+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+	45%

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For the period January 1, 1994 through December 31, 1995 if the sum of the adjustments pursuant to this subparagraph would exceed $36,000,000 for a rate year, the supplemental percentage coverage of need scale pursuant to this subparagraph shall be reduced on a prorate basis so that the sum of such adjustments provided for the rate year shall not exceed $36,000,000.

(iv) The scale utilized for development of a voluntary non-profit or private proprietary general hospitals' supplementary low income patient adjustment for the period May 15, 1993 through December 31, 1993 shall be at 120% of the supplemental percentage coverage of need scale specified in paragraph (2)(iii) of this section.

(3) The supplementary low income patient adjustment shall be limited for rate periods during January 1, 1991 through December 31, 1993 such that this amount, when added to the distribution determined pursuant to subdivision (d) of section 86-1.65 of this Subpart for the rate period, plus for a major public general hospital, the amount of any supplementary bad debt and charity care disproportionate share payments determined pursuant to section 86-1.74 for the rate period shall not exceed 90 percent of need as described in subdivision (b) of section 86-1.65 of this Subpart and calculated using 1989 data. In addition, in order to be eligible for an adjustment pursuant to this section, the hospital shall not be eligible for distributions as a financially distressed hospital pursuant to section 86-1.65(d)(3) of this Subpart and the hospital must maintain its collection efforts to obtain payment in full from self-pay patients.

(c) The supplementary low income patient disproportionate share adjustment provided in accordance with this section for rate periods during January 1, 1991 through December 31, 1993 shall be adjusted to reflect actual distributions made pursuant to subdivision (d) of section 86-1.65 of this Subpart and section 86-1.74 of this Subpart and actual service units as defined in subdivision (b) of this section.

TN 94-06 Approval Date NOV 21 1997

Supersedes TN 93-26 Effective Date JAN 01 1994

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